To file insurance and complete your claim form correctly, we've enclosed a copy of the HICFA form. (You can also obtain these from Mr. Fuller's office following a session).

The first sample gives instructions for the client to complete. Clients should complete the top portion (right & left side) indicating their name, address and insurance information (from your insurance card).

The 2nd sample below shows how a form should be completed with Mr. Fuller's information (you will need to transfer that info to the copy you send to your insurance company.).

Once the insurance form is completed, either bring the form to our offices at your next session...or fax it to us at 888-511-4707. Clifton Fuller will then sign it and fax it back to you (or have it available for you to pickup at the office).

IF you have an appointment already scheduled, you can also complete the form prior to the session and bring it to the session for his signature. Once filled out with your info & Mr. Fuller's info, you can make copies (so all you have to fill out each time is the date of service for future appointments.

Enter the address of your insurance company. Do not use any punctuations. See the example.

Feel Good Insurance Company
12 Market Street Suite 5
Anywhere NC 28135

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

PICA

CARRIER

PATIENT AND INSURED INFORMATION

1. MEDICARE (Medicare#) MEDICAID (Medicaid#) TRICARE (ID#/DoD#) CHAMPVA (Member ID#) GROUP HEALTH PLAN (ID#) FECA BLK LUNG (ID#) OTHER (ID#)

1a. INSURED'S I.D. NUMBER (For Program in Item 1)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)

3. PATIENT'S BIRTH DATE MM DD YY SEX M F

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street)

6. PATIENT RELATIONSHIP TO INSURED Self Spouse Child Other

7. INSURED'S ADDRESS (No., Street)

CITY STATE

8. RESERVED FOR NUCC USE

10 A-C should be marked no unless it's related to workers compensation or auto accident

CITY STATE

ZIP CODE TELEPHONE (Include Area Code) ( )

TELEPHONE (Include Area Code) ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (Current or Previous) YES NO

a. INSURED'S DATE OF BIRTH MM DD YY SEX M F

b. RESERVED FOR NUCC USE

b. AUTO ACCIDENT? PLACE (State) YES NO

b. OTHER CLAIM ID (Designated by NUCC)

c. RESERVED FOR NUCC USE

c. OTHER ACCIDENT? YES NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. CLAIM CODES (Designated by NUCC)

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO If yes, complete items 9, 9a, and 9d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED **Be sure to sign here** DATE **Enter the Date**

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED **Be sure to sign here also.**

PHYSICIAN OR SUPPLIER INFORMATION

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL.

15. OTHER DATE QUAL. MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM MM DD YY TO

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a.

17b. NPI

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM MM DD YY TO

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

The office staff will provide you with the ICD-9-CM code.

20. OUTSIDE LAB? $ CHARGES

Please enter the number 9 between the lines. 9 indicates you will be using an ICD-9-CM code.

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind.

A. 311 B. C. D.

E. F. G. H.

I. J. K. L.

22. RESUBMISSION CODE ORIG. REF. NO.

23. PRIOR AUTHORIZATION NUMBER

The charge amount will be provided by the office staff

24. A. DATE(S) OF SERVICE From MM	DD	YY	To MM	DD	YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1	05	01	14	05	01	14	11		99213		A	110 00	1		NPI	1609203413
2															NPI	
3															NPI	
4															NPI	
5															NPI	
6															NPI	

The date of service should be entered as shown. Use a 2 digit month, 2 digit day, and a 2 digit year.

The CPT code will be provided by the office staff. This code will vary depending on the time and type of service rendered.

Block 21A must have diagnosis code. This will be provided by the physician. Enter the letter A in block 24 E. Failure to complete this block will result in a denial.

The NPI is required for payment

Enter the amount you paid for this visit only.

25. FEDERAL TAX I.D. NUMBER SSN EIN 45 2652215 X

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES X NO

28. TOTAL CHARGE $ 110 00

29. AMOUNT PAID $ 20 00

30. RSVD FOR NUCC USE

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

SIGNED Clifton Fuller DATE

32. SERVICE FACILITY LOCATION INFORMATION

CH Fuller and Associates LLC
15303 Huebner Road Suite 10
San Antonio TX 78248

a. 1609203413 b.

33. BILLING PROVIDER INFO & PH # (210) 404-9001

Clifton Fuller LCSW 299 LPC LMFT
15303 Huebner Road Suite 10
San Antonio TX 78248

a. 1609203413 b.

NUCC Instruction Manual available at: www.nucc.org

PLEASE PRINT OR TYPE

APPROVED OMB-0938-1197 FORM 1500 (02-12)

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

PICA

1. MEDICARE (Medicare#) / MEDICAID (Medicaid#) / TRICARE (ID/DoD#) / CHAMPVA (Member ID#) / GROUP HEALTH PLAN (ID#) / FECA BLK LUNG (ID#) / OTHER (ID#)			1a. INSURED'S I.D. NUMBER (For Program in Item 1)
2. PATIENT'S NAME (Last Name, First Name, Middle Initial)	3. PATIENT'S BIRTH DATE MM DD YY / SEX M / F		4. INSURED'S NAME (Last Name, First Name, Middle Initial)
5. PATIENT'S ADDRESS (No., Street)	6. PATIENT RELATIONSHIP TO INSURED Self / Spouse / Child / Other		7. INSURED'S ADDRESS (No., Street)
CITY / STATE	8. RESERVED FOR NUCC USE		CITY / STATE
ZIP CODE / TELEPHONE (Include Area Code) ( )			ZIP CODE / TELEPHONE (Include Area Code) ( )
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)	10. IS PATIENT'S CONDITION RELATED TO:		11. INSURED'S POLICY GROUP OR FECA NUMBER
a. OTHER INSURED'S POLICY OR GROUP NUMBER	a. EMPLOYMENT? (Current or Previous) YES / NO		a. INSURED'S DATE OF BIRTH MM DD YY / SEX M / F
b. RESERVED FOR NUCC USE	b. AUTO ACCIDENT? YES / NO PLACE (State)		b. OTHER CLAIM ID (Designated by NUCC)
c. RESERVED FOR NUCC USE	c. OTHER ACCIDENT? YES / NO		c. INSURANCE PLAN NAME OR PROGRAM NAME
d. INSURANCE PLAN NAME OR PROGRAM NAME	10d. CLAIM CODES (Designated by NUCC)		d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES / NO If yes, complete items 9, 9a, and 9d.
READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM. 12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below. SIGNED ____ DATE ____			13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below. SIGNED ____

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY / QUAL.	15. OTHER DATE QUAL. MM DD YY	16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE	17a. / 17b. NPI	18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)		20. OUTSIDE LAB? YES / X NO $ CHARGES
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. Relate A-L to service line below (24E) ICD Ind. A. B. C. D. E. F. G. H. I. J. K. L.		22. RESUBMISSION CODE / ORIGINAL REF. NO. 23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE From MM DD YY / To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS / MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1	11			A		1		NPI	1609203413
2								NPI	
3								NPI	
4								NPI	
5								NPI	
6								NPI	

25. FEDERAL TAX I.D. NUMBER SSN EIN: 45 2652215 X	26. PATIENT'S ACCOUNT NO.	27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES / X NO	28. TOTAL CHARGE $	29. AMOUNT PAID $	30. Rsvd for NUCC Use
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.) SIGNED ____ DATE ____	32. SERVICE FACILITY LOCATION INFORMATION CH Fuller And Associates LLC 15303 Huebner Road Suite 10 San Antonio TX 78248 1609203413		33. BILLING PROVIDER INFO & PH # (210) 404-9001 Clifton Fuller LCSW 299 LPC LMFT 15303 Huebner Road Suite 10 San Antonio TX 78248 1609203413	

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CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION